

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35093

State File No.

Registrar's No.

OCT 28 1943

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Chicapeake
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: John ...
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

3. (b) If veteran, name war Spanish American 3. (c) Social Security No. _____

4. Sex 0 5. Color or race 1 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased January 18 - 1876
(Month) (Day) (Year)

8. AGE: Years 67 Months 8 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Iowa Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name George W. Duntor
13. Birthplace Iowa (City, town, or county) (State or foreign country)
14. Maiden name Anna Rachel
15. Birthplace Iowa (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mr. John Duntor
(b) Address Wm. V. ...

17. (a) Burial (b) Date thereof 10-3-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Orange cemetery

18. (a) Signature of funeral director Ad Wallace
(b) Address Ballwin, Mo

19. (a) 10-8-43 (b) Anna Whinnery
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Chicapeake
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Sept. 5, 1943, to Sept. 27, 1943;
that I last saw him alive on Sept. 27, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction - I
left side of heart, causing
Due to myocardial infarction
of left side of heart.
Due to myocardial infarction
check area
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none
Of operations 53
Of autopsy none

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Ernest L. Kiley (M. D. or other) M.D.
Address Chicapeake, Mo Date signed 10/27/43

RECEIVED
JAN 26 1944

District Health Officer No. 6;

District File Number 1043-1201

Date Filed OCT 27 1943

APR 24 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

....., Registered Apprentice No.
working under my personal supervision.

Signed

A. S. Wallace

Licensed Embalmer No.

2175

P. O. Address

Billings Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1124

Registration District No. 176

Primary Registration District No. 5651

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Chasebrook, Zumbach, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME Norman Jason Hunt

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Montgell 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan 18 (Month) (Day) (Year)

8. AGE: Years 67 Months 8 Days 1 Unless than one day min.

9. Birthplace (City, town, or county) (State or foreign country) Iowa

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Anna Whitney (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19 19 19 that I last saw him alive on 19 19 19 and that death occurred on the date and hour stated above. Immediate cause of death

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

JAN 26 1944

APR 24 1944

APR 18 1944

35093